DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
James Randolph Farris, M.D.
Regional Administrator

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December 5, 2001

Our Reference: WA-AR0188.90.R1.01

Mr. Ray Hanley, Director
Division of Medical Services
Arkansas Department of Human Services
Post Office Box 1437- Slot 1103
Little Rock, Arkansas 72203-1437
Att: Regina Davenport

Dear Mr. Hanley:

The State of Arkansas has submitted a request for an amendment to Arkansas Home and Community-Based Services waiver (HCBSW) No. 0188.90.R1.01. The waiver serves individuals in the community who would otherwise require the level of care provided in an intermediate care facility for the mentally retarded (ICF/MR). The State is requesting to include a fiscal intermediary option in the waiver program to include participant choice for self-direction and self -management of supportive living services within the waiver.

Based upon our review of the amendment request, we have determined that they do not fully conform to the statutory and regulatory requirements for the home and community-based waiver program. Please provide the following additional information and/or clarifications.

1. Page 10, Amendment Document
   Please clarify that the requested effective date is July 1, 2001.

2. Page 12, Item 22a
   The information provided states that all persons at the time of initial placement on the waiver must have a pre-approved interim plan of care for a three-month period. This pre-approved POC is limited in the number of services a recipient may receive during this interim period. Please explain what the need or purpose is for this interim plan of care. Will there be another assessment prior to the development of an official plan of care? Will the person be enrolled but not receiving all waiver services during this interim period? How will you be ensure the health and welfare of the person during this period?

3. Page 12, Item 22b

Please provide additional information/clarification regarding the statement that a person determined as waiver eligible has the option of receiving $1500 per year state general revenue in lieu of waiver services. If the individual is in need of institutional care, they should be offered the choice of waiver services or institutionalization. How does this conform to the freedom of choice requirements?

4. Page 13, Amendment Document

The State indicates that the consumer is responsible for compliance with State and Federal law, including drug screens and criminal background checks. Please clarify how will the consumer be able to accomplish these requirements. Will it also be a requirement that the criminal history check results are received prior to the employee starting to deliver services? Please provide information about the type of training provided to the direct caregiver that the consumer hires.

The document states that the Fiscal Intermediary receives up to 20% of the daily rate. The State needs to provide additional information on the cost for the Fiscal Intermediary. Will the rate vary, what would the maximum rate be? How would FFP be claimed?

5. Page 17, Other eligibility, item b

The document indicates that anyone may reject some or all waiver services. If the Plan of Care indicates that a certain amount, duration and scope of specific services is required to assist the individual to avoid institutionalization, those services must be provided or the recipient would not be a candidate for waiver participation. If this is the case, how would the State meet the health and welfare assurance with total recipient choice?
Also, you indicate that vacancies in converted ICF/MR facilities or DDS licensed community residential program will be offered to other persons. Does this mean that if a person rejects certain services they will be offered an alternative setting rather than institutional placement?

6. Page 18

The State indicates that DDS notifies the waiver providers as to the anniversary date of the plan of care and the providers must submit annual continued stay of reviews, etc. Please clarify if the provider evaluates the level of care as well as develops the plan of care.
In addition, the waiver amendment states the case manager and direct care provider may be the same business entity. Please provide additional information, as this appears to be a conflict of interest.

7. Page 19, Item h

The State needs to clarify if the consumer will also receive information about the Fiscal Intermediary option.

8. Page 20, Item 27

The State indicates that DDS will not provide any services exceeding Medicaid State Plan prior authorization limits. Please clarify if this means that no State Plan services will be provided in excess of the limits imposed in the State Plan.

9. Page 22, Level I

The information indicates that nursing facilities can be the residence of a MR/DD recipient. Unless there was an accompanying physical problem, please explain why this target group would be residents of a nursing facility.

10. Page 24, Level III, item a

Please explain what is meant by General Revenue must be available and in use for the existing service level with supporting general revenue to be used for the payment of Medicaid match in order for waiver conversion to occur.

11. Page 63, Case Management Services

The description of this service states that the parent/legal guardians may opt to provide their own case management in lieu of waiver case management. The description also states that for Level III, the case management entity may determine, develop, and approve plans of care. This would appear to be a conflict of interest if the parent/legal guardian is the case manager. The State needs to clarify that if the parents are performing the case management, they cannot also perform the level of care.

12. Page 64, Respite Care

The service definition references Child Care. CMS does not pay for Child Care; the State would need to revise the service definition. The State needs to provide additional information on the type of training that would be provided to the caregiver chosen by the consumer or parent. Who would provide the training to the caregiver and determine if the caregiver was competent to provide services.

13. Page 66, Supportive Living Services

The States needs to provide additional information on the type of training that would be provided to the caregiver chosen by the consumer or parent. Who would provide the training to the caregiver and determine if the caregiver was competent?

14. Page 78, Supplemental Support Services

Service Definition includes reference to nursing facility as a transitioning level of care; please provide information as to why this population would be in a nursing facility.

15. Page 79, Waiver Coordination, item 11

Please clarify if the waiver coordinator will also serve as the Fiscal Intermediary for respite care. Also, please clarify if the consumer would be required to use the same waive r coordination agency for the Fiscal Intermediary function as they use for waiver coordination. The State needs to provide additional information on the procedures to be used to access the waiver coordinator as fiscal intermediary. Please provide information on the cost for this service.

16. Appendix B-2

The amendment did not include a revised Appendix B-2. The current waiver document does include an individual provider for respite care or supportive living services. The State should

revise Appendix B-2. Please clarify if a criminal history check will be required for these providers.

17. Page 110, Appendix G-2

    The chart for factor D does not include the following services that are part of the renewal: pre-vocational services, specialized medical needs, companion and activities therapy. If these services are still applicable, they should be shown for Factor D.

18. Page 110, Appendix G-2, Waiver Yr3

    The figures in the total column for items 11 and 12 appear to be incorrect, please review for accuracy. Please provide information on Waiver Coordination services, the Average Annual units indicate 11 months, how will this work if they are the Fiscal Intermediary?

    179.68 days equals about 6 months of waiver participation. Case management exceeds this ALOS as does support living and waiver coordination. The average number of annual units per user cannot exceed the ALOS noted at the bottom of the D chart as stated above. You will need to revise your estimates for the services.

19. Page 111, Appendix G-2, Waiver Yr 4

    The figures in the total column for items 7 and Grand Total appear to be incorrect, please clarify. Please provide information on Waiver Coordination services, the Average Annual units indicate 11 months, how will this work if they are the Fiscal Intermediary?

20. Page 112, Appendix G-2, Waiver Yr5

    The figure for in the total column for item 7 appears to be incorrect, please clarify. Please provide information on Waiver Coordination services, the Average Annual units indicate 11 months, how will this work if they are the Fiscal Intermediary?

Under section 1915 (c) of the Social Security Act, a waiver request must be approved, denied, additional information requested within 90 days of receipt, or the request will be deemed granted. The 90-day period in this case ends on December 23, 2001. This constitutes a formal request for information and under section 1915 (f) of the Social Security Act, stops the 90-day clock. A new 90-day period will begin upon receipt of the State's written response.

Please contact me at 214-767-6278 if you have any questions regarding this request.

Sincerely,

Cheryl Rupley, Health Insurance Specialist
Medicaid Operations and Financial Management Branch
Division of Medicaid and State Operations